

BELLSOUTH

Mary L. Henze
Assistant Director-Policy Analysis

Suite 900
1133 - 21st Street, N.W.
Washington, D.C. 20036
202 463-4109
Fax: 202 463-4144

April 16, 1997

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APR 16 1997

Federal Communications Commission
Office of Secretary

Mr. William F. Caton
Acting Secretary
Federal Communications Commission
1919 M Street, NW, Room 222
Washington, DC 20554

Re: Federal-State Joint Board on Universal Service, CC Dkt No. 96-45

Dear Mr. Caton:

Today, the attached letter was delivered by the undersigned on behalf of BellSouth, SBC Communications, Pacific Telesis Group, and Ameritech to the office of Common Carrier Bureau Deputy Chief Levitz in connection with the above referenced proceeding.

Please call me if you have any questions.

Sincerely,



Mary L. Henze
Assistant Director - Policy Analysis

Attachment

cc: K. Levitz
S. Whitesell
T. Peterson
E. Maxwell

No. of Copies rec'd 021
List ABCDE

April 16, 1997

Ms. Kathleen B. Levitz
Deputy Chief, Policy
Common Carrier Bureau
Federal Communications Commission
1919 M Street, N.W., Room 500
Washington, DC 20554

Re: Federal-State Joint Board on Universal Service, CC Docket No. 96-15:
Questions Regarding Health Care

Dear Ms. Levitz:

This letter is a follow-up to an *ex parte* visit to your office on April 10, 1997 by Mary Henze of BellSouth Corporation, Marvin Bailey of Ameritech, Todd Silbergeld of SBC Communications Inc., and Robert Shives, of Pacific Telesis Group ("PacTel"), now a wholly owned subsidiary of SBC Communications Inc. (collectively, the "Assembled Companies"). This letter also builds upon ideas expressed in PacTel's *ex parte* letters to Elliott Maxwell dated, March 21, 1997 (the "March Maxwell Letter") and April 3, 1997 (the "April Maxwell Letter") (jointly the "Maxwell Letters") (copies attached). All of the contacts mentioned above were made regarding the healthcare aspects of the *Federal-State Joint Board Recommendation on Universal Service*, CC Docket No. 96-45.

1. The Act Does Not Require Equalization of Distance Sensitive Prices

During our April 10th meeting, the Assembled Companies asserted that Section 254 of the Telecommunications Act of 1996 ("Act") does not require distance sensitive price equalization for rural and urban areas. We reiterated our position that the Act only requires that rural health care customers pay a rate that is reasonably comparable to an urban rate for telecommunications services necessary to the provision of health care. We also recognized that the FCC may not agree with our unanimous position. Thus, while we continue to hold the position that the Commission has no authority to subsidize distance as a component of achieving reasonable comparability of rates, if the FCC decides to do so, without prejudice to any of the Assembled Companies rights to seek administrative or judicial review of any decision to subsidize distance, we offer the following proposal as a reasonable means to achieve the Commission's goal:

A. Qualified Rural Health Care Providers Should Only Be Subsidized For Connections To the Nearest Urban Area

Were the FCC to require distance equalization, the maximum distance for which a rural health care provider should be subsidized would be the distance from the rural provider's facility to the nearest urban area. For purposes of our proposal, we would define an urban area as any city that has a population of twenty-five thousand (25,000) or more people. Such a limitation would protect against an otherwise natural tendency for a subsidized rural provider to request telemedicine connections to far flung areas in search of the real or imagined "expert" in the field.

Without such a limitation, all rural health care providers could seek subsidization for high speed connections, for example, to the Mayo Clinic in Minnesota or Johns Hopkins in Maryland, for telemedical consultations. While both of the institutions mentioned above, as well as any number of other "definitive expert" facilities or institutions, i.e., ones that are recognized for excellence in certain disciplines, can provide services; it is equally clear that less well known and geographically closer facilities can provide similar services. If such requests to far flung geographic locations were fully subsidized, the rural health care fund would have to be immense.

Moreover, such subsidization would disadvantage health care providers in *urban* settings, because *urban* providers would not be able to connect to the Mayo Clinic, Johns Hopkins or other facilities of similar standing, on a subsidized basis. It was not Congress' intent to make rural health care providers *better off* than their urban counterparts, but to afford rural and urban health care providers comparable access to telecommunications services necessary for health care. Such a result is facilitated by limiting the subsidy of qualified rural health care providers to distances no longer than the connection to the nearest urban area.

B. Assuming Subsidization For Qualified Rural Providers, Such Subsidization Should Be Only For Mileage In Excess Of The Average Urban Rate

As noted in the Maxwell Letters, *urban* health care providers are by no means exempted from distance charges in connection with the purchase of telecommunications services. Indeed, due to the sheer size of some urban centers, in many cases, some such urban providers can pay more in distance charges than their similarly situated rural counterparts. Accordingly, blanket subsidization of

the distance sensitive prices that qualified rural health care providers pay, even to reach the nearest urban area, could result in major inequities between the urban and rural providers.

To minimize the inequity, we propose that the distances encountered by urban providers be factored into any mandated rural subsidy. Such a factor, if done on a state-by-state basis utilizing statewide averaging, would achieve the distance comparability sought by the FCC.

Urban providers who pay distance sensitive prices are as geographically disparate as the boundaries of the communities that define them as urban, rather than rural. These urban areas range from small population centers of approximately twenty-five thousand people to large metropolitan areas. Thus, a reasonable distance factor should take into account the potential distance charges paid by any of these urban providers. Accordingly, we urge that the longest geographical dimension of each city with a population of 25,000 or more within a state, be averaged together to arrive at that state's "standard urban mileage" figure. This figure would be representative of mileage charges paid by a state's urban providers for distance sensitive services. It would be the threshold distance above which a qualified rural provider could receive a subsidy.

For illustrative purposes, we include the following example,

A qualified rural California provider wishes to connect to another facility 100 miles away using a distance sensitive service, for example a T-1, which is assumed to be identically priced at \$25 per mile per month for both rural and urban areas (plus additional non-distance sensitive recurring charges). Excluding the non-distance sensitive recurring charges which are identical for rural and urban providers, ordinarily, such a service would cost the qualified provider \$2,500 per month.

For this example, the distance to the providers nearest urban area (defined as a population center of 25,000 or more) is 60 miles. Moreover, the standard urban mileage figure for California has been previously determined to be 10 miles. Thus, 50 miles of the qualified provider's 100 mile distance is eligible for subsidy ($60-10=50$). Accordingly, the qualified provider pays \$1,250 per month ($\$25/\text{mile} \times 50 \text{ miles}$) and the carrier obtains the reimbursement from the Fund for the remaining \$1,250 per month.

A key strength of our proposal is illustrated by the example noted above. The qualified rural health care provider could choose to connect anywhere, not just the nearest urban area, however, it will receive USF support based only on the distance to the nearest urban area. Choosing to connect to a closer urban area would reduce the amount that the health care provider itself has to pay, but it is not mandated to do so. Thus, the provider has an incentive to make rational telecommunications choices and the flexibility to make decisions based on criteria not entirely economic. Moreover, there are any number of non-distance sensitive services that could be utilized in lieu of T-1 which could increase this flexibility without impacting the Fund. See April Maxwell Letter. In conclusion, we feel that our proposal will minimize the impact upon the Fund, while meeting the needs of qualified rural health care providers.

2. The Commission Should Not Mandate Infrastructure Buildouts.

We would also like to comment further on a second point we discussed in our April 10th meeting. We stated that the Commission could not mandate infrastructure buildouts for rural health care providers because, among other things, the Act does not support such a mandate. We also pointed out that covering buildouts under the Fund is not competitively neutral and that current network investment is sufficient to meet demand. See March Maxwell letter at 7-8 for a fuller exposition of these salient points.

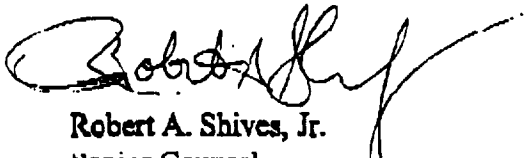
Finally, as also described in the March Maxwell letter and again at the April 10th meeting, it is our position that the Commission cannot mandate buildouts because it would not be "economically reasonable" to do so under Section 254(h)(2)(A). Commission precedent supports our conclusion. Indeed, the Commission's recent order in the Infrastructure Sharing docket interpreted a similar "economic reasonableness" clause in Section 259(b)(1) of the Act and concluded that under Section 259, "no incumbent LEC should be required to develop, purchase or install network infrastructure, technology, facilities, or functions... when such incumbent LEC has not otherwise built or acquired, and does not intend to build or acquire, such elements." Implementation of Infrastructure Sharing Provisions in the Telecommunications Act of 1996, CC Docket No. 96-237, Report & Order, FCC 97-36, ¶96 (rel. Feb. 7, 1997); see also Policies and Rules Concerning Operator Service Access and Pay Telephone Compensation, CC Docket No. 91-35. Memorandum Opinion and Order, DA 96-2169, paras. 4, 7, 9 (rel. Dec. 20, 1996) (Requirements that are "prohibitive," "unnecessarily costly" or impose "significant costs" are not economically reasonable).

Ms. Kathleen B. Levitz
April 16, 1997
Page Five


Because it would be "economically unreasonable" to mandate buildouts, the Commission should not mandate them in the health care context. If the FCC does require buildouts in some situations, each such buildout must first be put to the "economic reasonableness" test before a carrier is required to carry it out.

Thank you for your attention to our concerns.

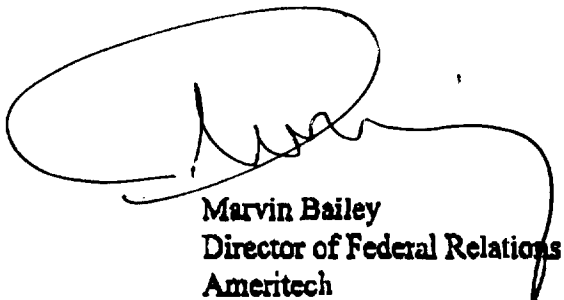
Respectfully yours,




Robert A. Shives, Jr.
Senior Counsel
Pacific Telesis Legal Group



Mary L. Henze
Assistant Director-Policy Analysis
BellSouth Corporation



Marvin Bailey
Director of Federal Relations
Ameritech



Todd F. Silbergeld
Director, Federal Regulatory
SBC Communications, Inc.

cc: Sarah Whitesell
Timothy Peterson
Elliott Maxwell

Sarah A Thomas

PACIFIC  **TELESIS**
Legal Group

April 3, 1997

Elliott Maxwell
Deputy Chief
Office of Plans and Policy
Federal Communications Commission
1919 M Street, N.W., Room 822
Washington, D.C. 20554

Re: *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45:
Questions Regarding Health Care

Dear Mr. Maxwell:

We are submitting this second letter to follow up on our *ex parte* meeting with you last month regarding the health care aspects of the *Federal-State Joint Board Recommendation on Universal Service*, CC Docket No. 96-45.

When we met with you, we stated that the Commission should not equalize the distance-sensitive charges paid by rural and urban health care providers. Rather, we stated, there is an important distinction between the *prices* rural health care providers pay -- that is, the bottom line figure on their bills -- and the *rates* they are charged for an increment of service. In our view, if an urban provider pays a *rate* of \$10 *per mile* for a distance sensitive service, the statute's only requirement is that a rural provider pay the same \$10 *per mile rate* and pay the same additional non-recurring charges as does an urban health care customer.

We agreed, however, to provide you information regarding actual distance factors for urban customers. In large urban areas such as the Los Angeles and San Diego metropolitan areas, health care providers pay for distances which may be as long or even longer than certain rural customers might encounter.

Elliott Maxwell
Deputy Chief
Page Two

The following are actual examples of what one very large Pacific Bell health care customer pays in T-1 distance charges in the Los Angeles and San Diego areas¹:

Location	Mileage	Mileage Charge	Add'l Recur'g Chgs	Total Chg/Mo.
Woodland Hills -- Panorama City (Los Angeles County)	33 miles	\$25/mile x 33 miles = \$825	\$350 + \$125 = \$475	\$1,300
Santa Monica -- Riverside (Los Angeles County -- San Bernardino County)	51 miles	\$25/mile x 51 miles = \$1,275	\$350 + \$125 = \$475	\$1,750
San Diego City -- Vista (San Diego County)	28 miles	\$25/mile x 28 miles = \$700	\$350 + \$125 = \$475	\$1,175

Thus, urban health care customers in large states with sprawling urban areas such as California may encounter fairly significant urban distance sensitive charges. If the Commission attempts to equalize urban and rural distance sensitive charges, it must do so based on a realistic view of the distances charges actual urban customers pay. The FCC must not assume that urban customers all face short distances and adjust the rural distances accordingly. If it does so, it will be ignoring the facts faced by the Los Angeles and San Diego customer described in the chart, and making rural health care customers *better off* than their urban counterparts.

It was clearly not Congress' intent to *favor* rural customers over urban ones. If an urban customer in California pays for 51 miles of distance -- as does the actual customer described in the table -- a rural customer should pay for no fewer miles than does the urban customer. Indeed, if the FCC eliminates distance-sensitive differences between urban and rural customers, rural customers in a state should pay no less than the *greatest* distance faced by *any* urban customer in that state. If this does not occur, rural customers will be *better off* than urban customers, contrary to the intent of the statute.

Of course, if a health care customer wishes to use ISDN service, which is the predominant service used for telemedicine in California, that service is billed at far lower rates than are T-1 lines.

¹ The prices quoted in this letter are based on our generally available tariffed rates. The vast majority of our health care customers buy their services out of the tariffs.

Elliott Maxwell
Depury Chief
Page Three

You also asked us to furnish you with figures on the number of ISDN lines in Pacific Bell territory. The numbers are as follows:

Year	Number of ISDN Lines
1994	25,683
1995	57,695
1996	108,765
1997 (as of Feb. 28, 1997)	116,362

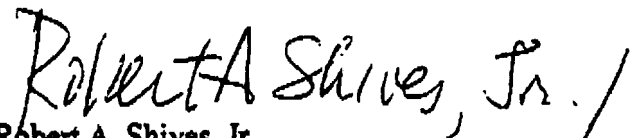
Pacific Bell currently has approximately 16 million access lines, of which approximately 10 million are residential access lines.

Please contact one of us if you need any further information. Thank you for your continued attention to our concerns.

Respectfully yours,



Sarah R. Thomas
Senior Counsel
(415) 542-7649



Robert A. Shives, Jr.
Senior Counsel
(510) 355-4028



cc: Lygiea Ricciardi
Astrid Carlson

Sarah R. Thomas
Senior Counsel

140 New Montgomery Street
San Francisco, California 94105
(415) 542-7649
Fax (415) 542-0418

PACIFIC  **TELESIS**
Legal Group

March 21, 1997

Elliott Maxwell
Deputy Chief
Office of Plans and Policy
Federal Communications Commission
1919 M Street, N.W., Room 822
Washington, D.C. 20554

Re: Federal-State Joint Board on Universal Service, CC Docket No. 96-45:
Questions Regarding Health Care

Dear Mr. Maxwell:

We write to follow up on our *ex parte* meeting with you earlier this month, and to provide further support for Pacific Telesis Group's recent comments on the health care aspects of the *Federal-State Joint Board Recommendation on Universal Service*, CC Docket No. 96-45. We make the following points:

- One size does not necessarily fit all. The Commission should not mandate a certain transmission speed, such as T-1 speed, as a required minimum.
- ISDN and other sub-T-1 speed services work very well for telemedicine projects in California. We describe several of these projects in detail below.¹
- The Commission should not equalize distance-sensitive costs incurred by urban and rural health care customers.
- The Commission should not mandate infrastructure buildouts as part of its decision on the health care aspects of universal service.

¹ We understand from our meeting with you that you are familiar with Pacific Bell's CalREN program. When CalREN funding began, project funding recipients were offered any amount of bandwidth and, with the exception of academic institutions who selected ATM speed, the recipients selected ISDN speed as adequate. None believed that a higher speed was a requirement for health care delivery. Some of these CalREN projects are highlighted here. We would be happy to supply more information on any of the projects outlined herein, or CalREN, if you feel it necessary.

Elliott Maxwell
Deputy Chief
Page Two

1. *One size does not necessarily fit all.*

The Commission should not mandate a certain transmission speed, such as T-1 speed, as a required minimum speed for all lines provided to health care providers as part of the universal service program. Instead, carriers should have a *choice* in determining the level of services they deploy to health care providers, as long as they can deliver certain essential services, described below. The carrier's choice is imperative in order to guard against unreasonable demands from unreasonable customers whose unchecked requests could require the carrier to incur unreasonable expenses to build out facilities where reasonable alternatives already exist.

If, as in Pacific's case, the carrier can demonstrate that a slower speed or less robust capacity, such as ISDN, meets the needs of the provider, then it should be allowed to provide this service. If, on the other hand, it makes more economic sense for a carrier to deploy faster lines, such as T-1 lines, the carrier should have this option, so long as the health care provider receives essential services. Such a rule would recognize that different regions are expanding their telecommunication infrastructures in different ways. In California, ISDN is deployed throughout the state. In some states, on the other hand, T-1 has been deployed in the preponderance of the state.

Because of these regional differences, we believe that there should not be a nationwide standard; rather, the mandated level of transmission speed should be the service currently deployed in each individual region. This is the most competitively neutral result: the Commission should not mandate a system that favors one type of service or technology over another; rather, as you indicated in our *ex parte* conversation earlier this month, the Commission should permit any transmission speed up to T-1 (1.54 Kbps).

In this regard, we believe the Commission should focus on whether certain essential services can be delivered to patients using telecommunications, rather than focusing on or dictating the *technology* used to deliver the services. In our view, the essential services available to rural patients and providers should consist of the following:

- Health care provider-to-patient communication over telephone lines to allow teleconsultation.
- Capability to send and receive data and medical images such as x-rays.
- Patient examination and counseling using electronic instruments such as electronic stethoscopes, ophthalmoscopes, otoscopes and EKGs.

Elliott Maxwell
Deputy Chief
Page Three

- Ability to transmit electronically the results of examinations conducted by the foregoing electronic instruments to assist the health care provider stationed at the remote end with diagnosis.

We recommend that the Commission periodically update this list of "essential services," so that it reflects what telemedicine projects and health care actually need and use. A process of periodic reevaluation will help the Commission "recalibrate" its requirements to reflect actual practice in telemedicine projects around the country.

In support of our position that the Commission should permit any transmission speed, including ISDN, we would point out that in a survey of 84 telemedicine projects nationwide, it was found that 62 were using *sub-T-1* speeds, ISDN or POTS lines. We believe that even in some states where T-1 is cited as the preferred transmission speed, the entire trunk is not used; rather, only a fraction of the T-1 is used.

The following are data reflecting transmission speeds used by telemedicine projects around the nation.²

Transmission Speed	Number of Locations
T1	22
1/2 T1	12
1/4 T1	25
ISDN	14
POTS	11

2. *Speeds less than T-1 speed work well for telemedicine in California.*

In California, telemedicine projects are using predominantly ISDN speed and some fractional T-1, with the exception of leading academic institutions experimenting with ATM Cell Relay for research purposes. What follows are examples of successful

² Source: Telemedicine Today, as reprinted by The American Telemedicine Association. Note that this source does not include ATM or switched 56 speed, both of which we describe in this letter. Switched 56, which operates at half the speed of ISDN, has been used successfully telemedically in three of the projects we describe in this letter. (See our descriptions of the Udkoff, Western Consortium and Heger projects herein.)

Elliott Maxwell
Deputy Chief
Page Four

California telemedicine projects working with far less than T-1 speed. We must caution that these descriptions are based on our best information about the projects described, and that any confirmation of this information or further input must be obtained from the projects themselves.

- **Telemedicine Emergency Neurosurgical Network ("TENN").** The Sutter Solano Medical Center is a community hospital that provides medical care to the Sutter and Solano County region's residents, as the region is without neurosurgical care. Dr. Paul Chodroff, a neurosurgeon at John Muir Medical Center in Walnut Creek, developed the Telemedicine Emergency Neurosurgical Network ("TENN"). Should a patient be brought to Solano Medical Center with a neurological emergency, Dr. Chodroff or one of the other neurosurgeons available 24 hours a day can immediately review digitally transmitted CT scans to determine if the patient can be treated locally, or needs to be transported to John Muir.

The attending physician at Sutter initiates standard telephonic contact with the neurosurgeon "on call" and the CT images are sent *via ISDN lines* to the specified site on the receiving network. The TENN is comprised of 10 Macintosh computers placed in either a participating neurosurgeon's home, office or hospital. CT images or MRIs are transferred across digital lines in *four minutes*.

One recent success of the TENN project is the story a young girl who was injured in Solano County and brought into the Medical Center for evaluation. Prior to the TENN project's initiation, she would have been automatically airlifted to John Muir, as diagnosis would not have been possible from a remote location. Because of the TENN project, the CT image was transmitted to John Muir where the doctors noted that this patient *would die if she experienced increased altitude* -- something the doctors in Solano County could not have known. The TENN project literally saved this young girl's life, by *avoiding* an airlift. As of last year, the TENN project had actually avoided the cost of thirty transports costing \$4,500 each.

- **Department of Mental Health, Riverside County.** The Riverside County Mental Health Department is conducting a psychiatry program using ISDN. Emergency room psychiatrists give telephone consultations, supervision and direction to non-MD mental health workers in clinics, jails and outreach services. Video-conferencing technology is used for psychiatrists to provide face-to-face patient assessment and treatment. The project has seen a decrease in the need to bring rural patients to urban physicians. The services provided include triage, crisis evaluation, and initiation and continuation of psychiatric treatment for selected patients.

Elliott Maxwell
Deputy Chief
Page Five

- ***Western Consortium for Public Health.*** The Western Consortium for Public Health is conducting a teleconferencing and remote-access demonstration project in California. Eleven out of 58 counties in the state are so geographically isolated that the state is chartered with providing public and environmental health services. Public health nurses are stationed in the isolated communities to provide these services. The nurses need the ability to provide public health services to their rural clients and also stay in close contact with their supervisors in Sacramento. In addition to demonstrating the effectiveness of telehealth and telemedicine, this project is also demonstrating the effectiveness of remote data entry/access via pen-based computing. The communications network uses ISDN and switched 56 Kbps service.
- ***Remote diagnosis of abused children.*** In 1993, Pacific Bell helped to fund a project which enabled the remote diagnosis of abused children. Still in operation today, the University of Southern California's Center for the Vulnerable Child Program links to distant desert locations using telemedicine for remote examination and diagnosis of children in rural areas in cases where physical or sexual abuse is suspected. High-speed ISDN and switched 56 Kbps service support multimedia teleconsultation allowing diagnosis, treatment and exchange of medical data. This project continues under Astrid Heger, M.D.
- ***Lytton Gardens.*** Lytton Gardens is another successful telemedicine project which began with Pacific Bell CalREN funding. It is, to our knowledge, the only skilled nursing facility using telemedicine in the nation, and is linked telemedically to Stanford University. The project utilizes 6 ISDN lines, and uses 512 Kbps for video with two lines left for data transmission. Stanford University's Liver Transplant Service is just one of the Stanford Medical Center departments using telemedicine to follow post-operation patients who are discharged from Stanford to Lytton Gardens following liver transplants. Other departments within Stanford using telemedicine include the vascular, plastic surgery and dermatology. We believe the involved doctors consider the ISDN transmission to be of diagnostic quality.
- ***Stanford Medical Center's Community Outreach project.*** Stanford's Community Outreach project is a telemedicine project which includes two other participants, the Drew Health Foundation and the San Jose Medical Group. The uniqueness of this program lies in the fact that urban East Palo Alto patients have always been referred to Stanford, but have often been unable to keep appointments because of the two hour bus ride required to travel the short distance to Stanford. Now, these same patients come to Drew Health Center instead, link up telemedically over ISDN lines with

Elliott Maxwell
Deputy Chief
Page Six

Stanford, and keep their appointments. EEGs and ultrasound test results are frequently transmitted and cardiology and dermatology are practiced — all via ISDN.

- *Teleradiology Network in Ventura, California.* Dr. Ranon Udkoff in Ventura established a successful teleradiology network involving four sites using switched 56, which operates at *half* the speed of ISDN. As the MRI practice has grown, Dr. Udkoff has upgraded to 128 Kbps sent over frame relay. Dr. Udkoff considers images sent over 128 Kbps with zero compression to be perfectly adequate for a busy MRI center.³ We were informed of an extraordinary example of the network's effectiveness when it was still at switched 56 speed. A 29-year old rural woman gave birth to a healthy baby. A week later the woman was rushed to the hospital with headaches and visual problems. An MRI was scheduled and the results were scanned to Dr. Udkoff 70 miles away, as there was no radiologist available in the rural hospital to which the patient was admitted. Within thirty minutes the images had been transmitted over a switched 56 line to a filmless reading station. In this case, an unnecessary admission was avoided, as the patient's condition was not serious.

3. The Commission Should Not Equalize Distance Sensitive Pricing

We believe there is an important distinction between the *prices* rural health care providers pay — that is, the bottom line figure on their bills — and the *rates* they are charged for an increment of service. In our view, if an urban provider pays a *rate* of \$10 per mile for a distance sensitive service, the statute's only requirement is that a rural provider pay the same \$10 per mile *rate*. It may be that the price the rural provider pays is higher because it is more distant from the central office than is the urban provider, but so long as these *rates* are equalized, the carriers have satisfied the Act's requirements. In other words, a rural health care provider that is 100 miles from the nearest central office should not pay the same distance-sensitive net amount as an urban provider that is two miles from the central office.

We are mindful of the questions you raised regarding distance equalization during our recent *ex parte* contact. We will be sending a follow-up letter shortly which identifies large distance factors for urban customers.

³ Dr. Udkoff is willing to offer a testimonial should a member of the Commission be interested in speaking with him.

Elliott Maxwell
Deputy Chief
Page Seven

4. *The Commission Should Not Mandate Infrastructure Build-Outs*

We strenuously object to the Joint Board's recommendation to the extent it assumes that Section 254 requires carriers to *build out* their facilities to serve customers not currently served. This interpretation would swell the fund to insupportable levels, is unnecessary given current industry initiatives and build out schedules, would create incentives for carriers to finance infrastructure expansion from the universal service fund, and is inconsistent with the statute.

In addition to being exorbitant, requiring carriers to build out their networks by regulatory fiat may be unnecessary. Carriers already have aggressive build out plans, and are also engaged in private initiatives to bring telemedicine and other services to urban and rural health care providers, as well as other customers. There are currently over 130 telemedicine projects listed on the Telemedicine Information Exchange ("TIE") Web Page, which covers the entire nation. The American Telemedicine Association lists eight telemedicine projects in California, which is tied with Pennsylvania and North Carolina with the greatest number of projects in the country. California has other telemedicine projects which are not included on the TIE page because commercial projects are not tracked in the same way government projects are monitored. There are at least ten projects in California that we are aware of, more than any other state. In addition, recent legislation passed in California requires reimbursement of telemedicine expenses just as with face-to-face exams; we believe this law will stimulate demand for telemedicine, and that the market will respond to this demand on its own. Build outs will not be necessary.

Furthermore, it is bad public policy to subsidize large network upgrade projects with universal service dollars. Those carriers that have already built out their networks will be penalized by having to subsidize those that have not and seek to do so with universal service funding. In some cases, carriers will be funding build outs of their own competitors. Moreover, infrastructure build outs inevitably will be used for applications other than health care. However, once universal service fund dollars are spent on such upgrades, it will be difficult to reclaim them when carriers begin using new infrastructure for other uses.

Moreover, nothing in Section 254 requires construction of infrastructure in order to bring services to rural health care providers. The Joint Board appears to rely on Section 254(h)(2)(B) ("The Commission shall establish competitively neutral rules . . . to define the circumstances under which a telecommunications carrier *may be required to connect its network* to . . . public institutional telecommunications users."). (Emphasis added.)

Elliott Maxwell
Deputy Chief
Page Eight

However, Section 254(h)(2)(A) makes clear that any requirement that a carrier "connect its network to . . . public institutional telecommunications users" must be "technically feasible *and economically reasonable*." (Emphasis added.) It is not economically reasonable to require carriers to build out entire new networks -- at high speeds -- to rural areas in order to bring telemedicine to rural hospitals.⁴ Nor is such a requirement "competitively neutral" (47 U.S.C. § 254(h)(2)), as it is probable that the burden of such construction would fall disproportionately on ILECs and carriers of last resort.

An across-the-board buildout requirement will subvert the economic reasonableness requirement of Section 254(h)(2). Because of this requirement, the Commission must either devise a process for individual determinations of the economic reasonableness of individual buildout decisions, or prohibit buildouts altogether.

Moreover, even if the Commission orders buildouts, it should not order *overbuilds* where there are existing facilities. Facilities-based competition should not be funded from scarce universal service dollars.

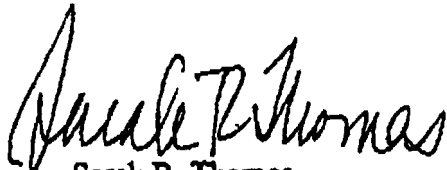
Finally, Section 254(c)(1) requires the Commission to consider the extent to which services "are being deployed in public telecommunications networks by telecommunications carriers" in determining their eligibility for universal service support. By definition, services which require build outs are not already "being deployed." Because the health care provision of the statute does not state that Section 254(c) is irrelevant, Section 254(h) must be read in conjunction with the limitations in Section 254(c) so as to limit the range of services that will be funded by scarce universal service resources.

⁴ See *In the Matter of Implementation of Infrastructure Sharing Provisions in the Telecommunications Act of 1996*, CC Docket No. 96-237, FCC 96-456, ¶ 20 (rel. Nov. 22, 1996) ("In determining what is economically unreasonable, we tentatively conclude that no incumbent LEC should be required to develop, purchase, or install network infrastructure, technology, facilities or functions solely on the basis of a request from a qualifying carrier to share such elements when such incumbent LEC has not otherwise built or acquired and does not intend to build or acquire such elements.").

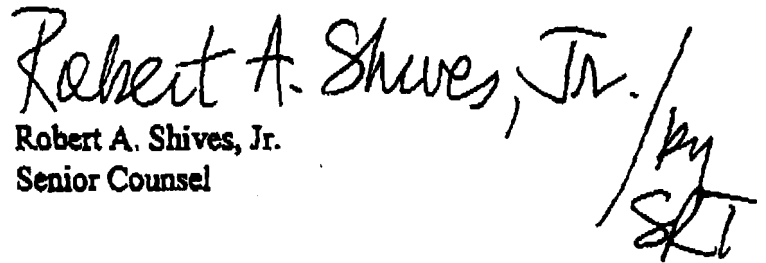
Elliott Maxwell
Deputy Chief
Page Nine

We appreciate your attention to our concerns.

Respectfully yours,



Sarah R. Thomas
Senior Counsel



Robert A. Shives, Jr.
Senior Counsel

cc: Lygiea Ricciardi
Astrid Carlson